

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037703

FILED VS OCT 21 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-9299**

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2217a St. Louis		d. STREET ADDRESS (If outside, give location) 2217a St. Louis	
3. NAME OF DECEASED (Type or print) First Middle Last Clementine H. Horstmann		4. DATE OF DEATH Month Day Year Oct. 9-1959	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/18/1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Charles Green		13b. MOTHER'S MAIDEN NAME Angusta Kelly	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Infarction		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension & Atherosclerosis		2 yr	
DUE TO (c) Stroke		2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 9-8-59 to 10-9-59 and last saw her alive on 10-8-59 Death occurred at 10-9-59 2:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J.D. Peck (Degree or title)		22b. ADDRESS 2505 W. T. Horstmann	22c. DATE SIGNED 10-10-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10/12/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis Ave. ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 10 1959	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

S.P.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gustav W. Dickstein

Licensed Embalmer No. H 374

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.